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When Respect for Autonomy Becomes Clinical Abandonment: A Relational Account of Supported Choice

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Abstract

Respect for patient autonomy is commonly associated with protecting persons from unwanted interference, yet clinical restraint can become ethically inadequate when patients are left to manage difficult choices without support that could preserve meaningful agency. This original normative–conceptual article examines the point at which respect for choice risks becoming clinical abandonment. It distinguishes formal decisional freedom from practically supported choice and argues that autonomy should be understood relationally without collapsing patient authority into professional guidance, family preference, or institutional convenience. Drawing on bioethical, clinical communication, shared decision-making, and relational-autonomy scholarship, the analysis develops a proposed account of supported choice in which clinicians may have obligations to provide proportionate informational, interpretive, deliberative, and relational assistance while preserving the patient's authority over the decision. Relational abandonment is proposed as normatively plausible when meaningful decisional vulnerability or burden is present, feasible autonomy-supporting assistance is available, professional withdrawal is material, consequences of unsupported choice are reasonably foreseeable, the patient has not declined assistance, and meaningful choice remains possible. This account does not treat influence as inherently autonomy-violating: support, persuasion, paternalism, and coercion require separate analysis according to their purposes, methods, and effects on decisional authority. The resulting framework is a conceptual synthesis rather than a validated clinical instrument or universal rule. Its application remains sensitive to capacity, culture, family relationships, resource constraints, genuine option availability, patient preferences for guidance, and institutional context.

Keywords: Autonomy, Relational autonomy, Supported choice, Shared decision-making, Clinical ethics, Patient participation

Introduction

Respect for autonomy is often expressed clinically through restraint: disclose relevant information, establish voluntariness and capacity, avoid coercive interference, and permit the patient to decide. Those protections remain indispensable. Yet they may be insufficient when a patient is frightened, overwhelmed, uncertain about values, or dependent on professional interpretation. Recent conceptual work on end-of-life care argues that shared and supported decision-making can complement one another because active assistance need not displace patient agency [1]. The problem developed here begins at that boundary: a clinician may avoid overriding a patient's decision while still withdrawing too far from the relational work through which that decision becomes understandable and genuinely attributable to the patient.

The practical importance of this distinction is visible in evidence that involvement itself can become burdensome. Patients with cancer have described uncertainty, responsibility, and need for guidance as features of treatment decision burden, while a meta-synthesis of relational autonomy found that supportive

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relationships and broader information may facilitate autonomy whereas dominant professional voices and undue pressure may inhibit it [2, 3]. These findings do not establish abandonment. They do show why "being given the decision" cannot be equated with being adequately enabled to decide.

The ethical problem is therefore not interference versus noninterference in the abstract, but whether professional conduct preserves both patient authority and the conditions under which that authority can be meaningfully exercised. Communication failures can produce "empowerment failure," leaving patients nominally empowered but insufficiently assisted to make decisions reflecting their goals and circumstances [4]. Contemporary shared decision-making likewise requires deliberative work, attention to vulnerability and power, and sensitivity to how much responsibility patients want to assume [5]. This article proposes relational abandonment for a narrower class of failures in which autonomy-compatible support is feasible, the patient has not rejected it, and professional withdrawal foreseeably leaves decisional authority without sufficient assistance.

The claim is deliberately bounded. Patients may prefer minimal guidance or reasonably choose options clinicians regard as imprudent. Noninterference can therefore be morally necessary, particularly when further professional influence would burden or distort a settled decision. The proposed distinction is between respecting a choice and withdrawing from the person making it. Respect for refusal of intervention should not automatically become refusal of continued support; clinicians can remain available, clarify consequences, and acknowledge uncertainty without reclaiming authority over the decision.

The individualistic interpretation of respect for autonomy

The target of this argument is not autonomy itself, nor liberal protection against coercion, but a thin clinical interpretation in which autonomy is treated chiefly as insulation from outside influence. On that interpretation, the ethical task is substantially complete once the patient receives information, demonstrates capacity, and is permitted to choose without overt pressure. Relational-autonomy scholarship challenges the sufficiency of this picture. Gómez-Vírseda and Amo Usanos argue that the isolated, self-sufficient chooser is inadequate for contexts in which dependence and interconnection are unavoidable [6]. Independence remains valuable, but it cannot be the sole measure of respectful care.

Clinical choice is also interpretive. Patients do not merely select among technical alternatives; they attempt to understand what those alternatives mean for bodily integrity, identity, relationships, future possibilities, suffering, and acceptable risk. Phenomenological analysis of clinical decision-making emphasizes that autonomy is exercised through lived and situated experience rather than abstract preference alone [7]. A formally expressed preference may therefore remain authoritative while arising within conditions that deserve ethical attention.

An overly individualistic interpretation can also produce a role inversion: in trying to avoid paternalism, the clinician becomes only an information provider and executor of whatever preference emerges. Yet patients often depend on professional expertise to interpret uncertainty, compare options, and identify questions not yet considered. A patient may also want a recommendation while retaining the right to reject it. Treating every recommendation as suspect can therefore mistake absence of influence for presence of autonomy. That dependence does not license clinicians to define the patient's good. It supports a distinction between shaping the decision and supporting the patient's authorship of it. This distinction is normative rather than semantic. The central question is whether professional participation enlarges the patient's ability to understand, evaluate, and own the decision or instead substitutes another person's judgment. The proposed relational account therefore retains a strong anti-paternalist core: a competent patient's considered decision remains theirs, while noninterference becomes one necessary condition of autonomy-supportive care rather than its complete content.

Formally free but practically unsupported choice

A choice can be formally free while remaining practically difficult to exercise. This occurs when the patient retains decisional authority yet lacks sufficient support to understand the choice, connect information to personal values, manage burden, or navigate competing pressures. Information disclosure alone does not ensure usable understanding. Recent normative analysis of informed-consent scaffolding argues that autonomy may require assistance with information processing and values clarification rather than mere access to facts [8]. Although that analysis concerns large language models

as possible scaffolding tools, its relevant conceptual point is broader: assistance can enlarge practical agency without transferring decisional authority to the supporter. Practical support is also culturally and socially situated. A systematic review of patient autonomy in the Global South identified family relationships, religion, social norms, clinician authority, health literacy, and structural conditions among factors shaping how autonomy is understood and exercised [9]. Such findings caution against assuming that the autonomous patient invariably wishes to decide alone or that family participation necessarily constitutes interference. They equally caution against romanticising relationality, because collective norms and professional hierarchy can constrain voice.

"Practically unsupported choice" is proposed here to describe a gap between retained authority and inadequate conditions for exercising it. The category is not synonymous with incapacity, indecision, vulnerability, or dissatisfaction with outcome. It is also distinct from the ordinary difficulty of tragic choices: clinicians cannot remove uncertainty, create unavailable treatments, or guarantee that a patient will feel confident. The relevant concern is avoidable lack of support within an otherwise genuine decision process.

A capable patient may need interpretive assistance; another may explicitly prefer no further discussion. Support must therefore be responsive rather than compulsory. More professional involvement is not automatically more autonomy-enhancing: repeated questioning, value-laden framing, or pressure can themselves compromise authorship. Calibrated assistance instead asks what help is necessary for this patient, in this decision, while leaving the final authority where it belongs. This formulation prevents the concept from turning every difficult or emotionally painful choice into evidence of professional failure.

Relational autonomy and the obligations of clinical support

Relational autonomy provides the strongest conceptual basis for explaining why support can matter without converting clinicians into substitute decision-makers. An argument-based systematic review of end-of-life ethics found multiple uses of relational autonomy rather than one settled doctrine, while contextual analysis emphasizes that decisions are embedded in histories, relationships, dependencies, and social conditions [10, 11]. This plurality matters. Relational autonomy should not function as a licence for greater professional involvement; here, its defensible role is diagnostic, directing attention to conditions that enable or constrain authorship.

Vulnerability clarifies the point. Professional reasoning examined through moral case deliberation indicates that vulnerability and autonomy need not be treated as opposites and that relationships may help sustain agency in difficult situations [12]. The inference proposed here is conditional: when vulnerability or decisional burden makes support materially relevant, and assistance can be offered without substituting professional judgment, clinicians may have an autonomy-based reason to remain engaged. That reason arises from the decision's relational structure and the clinician's distinctive capacity to assist, not from an assumption that vulnerable patients are less entitled to authority.

Family involvement presents a parallel test. Care-ethical analysis of shared decision-making shows why partners and relatives should not be treated simply as external intrusions into an isolated patient-clinician encounter [13]. They may provide memory, emotional security, practical knowledge, or help articulating values; they may also dominate or displace the patient's priorities. Relational support must therefore be judged by its effect on agency, not by who provides it.

This article consequently proposes a limited obligation of clinical support: to offer proportionate informational clarification, interpretation of uncertainty, deliberative guidance, and facilitation of supportive relationships when these are relevant, feasible, welcomed or reasonably needed, and compatible with preserved patient authority. The obligation weakens or disappears when assistance is refused, cannot improve meaningful decisional conditions, would itself become controlling, or urgent circumstances make extended deliberation impossible. The clinician's task is not to engineer preferences but to avoid withdrawing from the decisional relationship when continued, non-substitutive support is ethically warranted.

When respect becomes abandonment: normative conditions

Relational autonomy does not by itself establish a duty to provide every form of help. The stronger claim requires conditions that explain why withdrawal is ethically defective rather than merely sparse. A recent procedural account of relational autonomy in end-of-life care organizes autonomy through interacting personal, relational, and contextual dimensions [14]. That

approach supports structured examination of the decision environment, but it does not validate a threshold for abandonment. The present article therefore proposes relational abandonment as a conjunctive judgment about support, authority, and avoidable withdrawal.

The first condition is material vulnerability or decisional burden relevant to the choice. The second is availability of feasible support capable of improving the conditions of deliberation without taking the decision away from the patient. Third, the consequences of leaving the patient unsupported must be reasonably foreseeable in the limited sense that continued withdrawal predictably leaves an important decisional need unmet. Fourth, professional withdrawal must be material rather than trivial: failure to answer an irrelevant question is not abandonment. Fifth, the patient must not have declined the relevant assistance. Finally, meaningful choice must remain possible; clinicians cannot support a choice among options that do not exist.

This account also requires caution about interpersonal influence. Analysis of medically assisted dying argues that influence by another person should not be collapsed into coercion merely because relationships affect choice [15]. The same point limits the abandonment concept. A clinician who recommends, questions, or explores a patient's reasons is not necessarily violating autonomy; conversely, a clinician who says “the decision is yours” has not necessarily supported it. The normative issue is whether involvement helps sustain the patient's authorship or instead replaces, manipulates, or evades it.

Relational abandonment is thus proposed as an ethical description of a specific omission, not a diagnosis, legal category, or outcome measure. It should apply only where support is both autonomy-relevant and reasonably available, withdrawal is significant, and continued engagement could occur without overriding the patient's authority. The concept is intentionally narrower than poor communication and broader than literal desertion. It also requires proportionality. A clinician need not eliminate every uncertainty or assume responsibility merely because a decision is difficult. The proposed concern arises when an unmet need is material to deliberation and reasonable assistance could be provided without displacing the patient. This prevents ordinary limits of medicine from being automatically redescribed as abandonment while leaving serious support failures ethically visible.

Distinguishing support, persuasion, paternalism, and coercion

Clinical influence is ethically heterogeneous. Analyses of physician-patient communication distinguish different paternalistic forms rather than treating paternalism as a single act of overt override [16]. Observational work in palliative consultations likewise identifies persuasive communication through recommendations, framing, argument, and other attempts to shape judgment [17]. Professional influence in clinical communication is ethically heterogeneous and includes analytically distinguishable paternalistic and persuasive forms [16, 17]. The distinction therefore cannot rest simply on whether the clinician speaks forcefully or has an opinion. Supported choice is assistance ordered toward the patient's capacity to understand, deliberate, articulate values, and decide. Persuasion goes further by intentionally seeking to alter the patient's judgment through reasons, recommendations, or framing while leaving the formal decision with the patient. Paternalism arises when professional judgment is given controlling priority over the patient's preference or decisional process for the patient's presumed good. Coercion is more severe: voluntariness is constrained through threats, controlling pressure, or comparable means that make refusal unacceptably costly. These categories can overlap at their boundaries, but their ethical risks differ.

Abandonment and passive noninterference occupy the opposite side of the involvement problem. Both may involve little professional influence, but abandonment is proposed to involve ethically significant withdrawal where support is warranted, whereas passive noninterference may be appropriate when the patient prefers independence, the decision is settled, or further involvement would itself become intrusive. The ethical aim is therefore not maximal professional participation. It is calibrated participation that protects both meaningful agency and decisional authority and is presented in **Table 1**.

Table 1. Normative distinctions among clinical responses to patient choice

Response	Professional involvement	Respect for expressed preference	Degree of influence	Preservation of decisional authority	Principal ethical risk

Abandonment (proposed)	Inadequately withdrawn despite relevant support need	Formally respected	Minimal	Formally retained but practically unsupported	Mistaking withdrawal for respect
Passive noninterference (proposed distinction)	Deliberately limited	Respected	Low	Preserved	Under-support if circumstances change
Supported choice (proposed framework category)	Active, proportionate assistance	Respected and explored	Facilitative	Preserved	Support becoming directive
Persuasion	Active recommendation or reasoning	Preference may be challenged	Deliberate	Generally retained	Manipulation or excessive pressure
Paternalism	Directive or substitutive involvement	Partly overridden or subordinated	High	Reduced	Professional judgment displacing patient authority
Coercion	Controlling intervention or pressure	Not meaningfully respected	Controlling	Seriously compromised	Loss of voluntariness

Note: Categories synthesize evidence-informed distinctions from the approved literature; the abandonment, passive-noninterference, and supported-choice positioning is original proposed synthesis rather than a validated classification.

The supported-choice framework

Supported decision-making demonstrates the conceptual possibility of assisting persons whose autonomous functioning is constrained without automatically transferring the decision to another party [18]. The proposed Supported-Choice Framework extends that insight to clinical situations in which a patient may retain decision-making authority yet require help to exercise it meaningfully. It asks two questions simultaneously: how much autonomy-relevant professional support is being provided, and how fully is patient decisional authority preserved?

Shared decision-making scholarship emphasizes that meaningful participation requires work: identifying that a decision exists, exchanging information, considering preferences, deliberating, and connecting evidence to what matters to the patient [19]. The framework treats this work as potentially autonomy-enabling rather than inherently intrusive. But the horizontal increase in support is not an ethical progress scale. Support can become persuasive, paternalistic, or coercive depending on purpose, manner, and effect.

Relational pressure further complicates classification. Clinical ethics analysis shows why allegations of pressure require distinguishing coercion from relational influence rather than assuming that any strong interpersonal effect defeats autonomy [20]. Accordingly, the framework locates responses by preserved authority as well as professional involvement. Supported choice occupies the proposed zone in which assistance is active but the patient retains authority to accept, reject, revise, or end that assistance.

A difficult boundary arises when patients actively invite professional direction. The argument for consensual paternalism illustrates why patient-authorised guidance challenges a strict autonomy-versus-paternalism binary [21]. The present framework does not resolve that controversy by relabelling all invited direction as supported choice. Instead, it asks whether the patient continues to control the scope of delegated guidance and can meaningfully reclaim decision authority. Where that control disappears, the practice moves away from supported choice even if initially invited. The framework therefore treats authority as revisable rather than transferred once and for all. A patient may ask, “What would you recommend?” and later reject the recommendation; may invite family participation and later restrict it; or may initially seek extensive deliberation and later request closure. Supported choice remains compatible with these shifts only if clinicians continue to recognise the patient's capacity to redefine the terms of assistance. This makes responsiveness, not a predetermined amount of participation, the practical expression of the framework.

Figure 1 integrates these distinctions into a two-dimensional supported-choice spectrum. It maps the degree of autonomy-relevant clinical support against the degree to which patient decisional authority is preserved**,** thereby separating professional involvement from professional control. The figure identifies supported

choice as the proposed zone in which informational, interpretive, deliberative, or relational assistance increases while authority remains with the patient. It also shows why the neighboring positions are ethically distinct: insufficient support despite retained formal authority may approach relational abandonment; limited involvement may constitute justified noninterference when it reflects patient preference and adequate decisional conditions; and increasing professional influence may move beyond support toward persuasion, paternalistic substitution, or coercive control when the patient's ability to accept, reject, revise, or terminate that influence is progressively weakened. The figure should therefore be read as a normative map of clinical response patterns rather than a linear continuum of ethical quality. Its boundaries are deliberately permeable because the classification of any encounter depends on the purpose, proportionality, method, context, and effect of professional involvement on the patient's continuing authorship of the decision **(Figure 1)**.

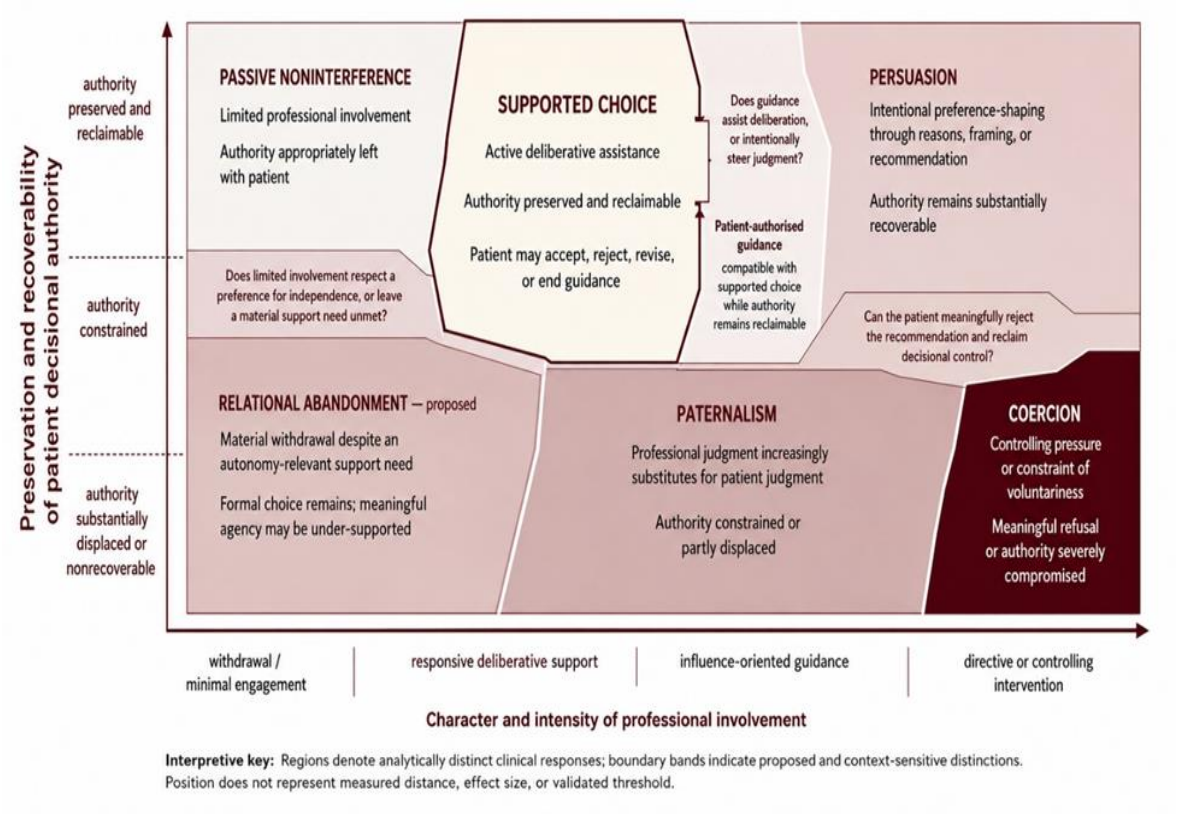

Figure 1. Clinical support and patient decision authority across the supported-choice spectrum

Table 2 presents questions which are proposed.

Table 2. Criteria for identifying relational abandonment in supported decision-making

Criterion	Proposed interpretive question	Boundary against overclaim
Vulnerability	Does illness, dependency, distress, or context materially affect the patient's ability to navigate this choice?	Vulnerability alone does not justify override
Decisional burden	Is responsibility for choosing creating a support-relevant cognitive, emotional, or interpretive burden?	Difficulty alone is not abandonment
Availability of feasible support	Is proportionate information, interpretation, deliberation, or relational assistance realistically available?	No duty to provide impossible support
Foreseeability of consequences	Is it reasonably foreseeable that withdrawal will leave an important decisional need unsupported?	Does not require prediction of clinical outcome

Degree of professional withdrawal	Is disengagement substantial relative to the patient's support need?	Minor omissions are insufficient
Patient preference for assistance	Has assistance been requested, welcomed, or not refused after an appropriate offer?	A competent refusal of support must be respected
Preservation of meaningful choice	Can assistance be offered while genuine options and patient decisional authority remain?	Support cannot manufacture unavailable options

Note: The criteria and their conjunctive use constitute an original proposed normative synthesis. They are not validated diagnostic thresholds, legal tests, or clinical performance measures.

Objections and boundary conditions

A first objection is that relational abandonment smuggles paternalism back into autonomy by converting professional assistance into an obligation. That risk is genuine. The framework therefore gives patient preference for assistance independent normative weight: a competent patient may choose minimal discussion, decline recommendations, or accept uncertainty. The duty proposed here is primarily to make proportionate support available and to avoid premature withdrawal, not to compel deliberation.

A second objection concerns cultural variation. Qualitative research on informed consent in Pakistan describes tensions between individualistic autonomy norms and contexts in which family participation, clinician authority, and collective values have greater practical significance [22]. Such evidence does not justify cultural relativism or family substitution. It does require caution before treating solitary decision-making as the universal benchmark of authentic choice.

Third, support cannot create a genuine decision where clinical options are absent. A systematic review and metasynthesis of palliative cancer care found that shared decision-making occurs within contexts where equipoise and available choices may be limited [23]. The framework therefore presupposes some meaningful domain of patient agency, even if that domain concerns goals, trade-offs, timing, or manner of care rather than selection among equivalent treatments.

Other hard cases include fluctuating capacity, emergencies, severe communication barriers, abusive family relationships, scarcity, and irreducible disagreement about what constitutes useful support. These do not refute the framework, but they restrict its reach and require case-sensitive judgment rather than mechanical classification. Resource scarcity adds a particularly difficult objection. If appropriate support is unavailable because a service lacks time, interpretation, continuity, or specialist input, responsibility cannot simply be assigned to the individual clinician. The framework is therefore capable of identifying an ethically problematic support gap without presuming personal blame. Distinguishing professional omission from institutional incapacity is essential if relational abandonment is to remain a useful normative category rather than a retrospective accusation.

Clinical and institutional implications

The proposed account changes the practical ethical question from “Did the clinician leave the decision to the patient?” to “Was the patient left with authority and sufficient support to exercise it?” That question may involve more than physicians. Qualitative analysis of patient participation in nursing care describes decision-making as relational across patients, families, and nurses, with participation varying from collaborative to more unilateral patterns [24]. Responsibility for autonomy support may therefore be distributed across the care team, although precise duties remain context-dependent.

Institutions should also examine whether support is equitably available. Secondary pooled analyses of clinical encounters found associations between some patient characteristics, including education, and observed involvement, while structured conversation tools altered some observed differences [25]. These findings do not establish a causal remedy, but they support scrutiny of whether communication time, interpreters, accessible information, and opportunities for deliberation are distributed unevenly. A relational account of autonomy is ethically incomplete if only well-resourced patients can obtain the support needed to make authority practically usable.

Support may additionally concern continuity of identity and relationships, particularly where illness threatens ordinary forms of self-expression. The relational care framework developed for person-centred dementia care emphasizes continuity or maintenance of selfhood through caring relationships [26]. Its direct scope should not be generalized to every competent adult, but it illustrates why autonomy-supporting care may involve more than transferring facts.

Institutional implications should remain proportionate. The framework does not establish a staffing ratio, mandatory consultation pathway, or standardized intervention. More defensible steps include recognizing decisional support as ethically relevant work, preserving routes for patients to request more or less guidance, documenting significant preferences about involvement, and creating opportunities to revisit decisions when circumstances change. These are implications of the proposed analysis, not evidence of implementation effectiveness. A further implication concerns professional education. Training that presents autonomy mainly as "giving patients the choice" may underprepare clinicians for the ethical difference between respecting refusal, offering guidance, and relinquishing deliberative responsibility. Educational use of the framework could therefore focus on case comparison: what assistance was available, what the patient wanted from the clinician, which forms of influence were present, and whether authority remained genuinely recoverable. Such teaching would require evaluation before claims could be made about changes in behaviour or patient outcomes.

Institutional ethics processes may also benefit from separating disputes about the content of a patient's decision from disputes about the quality of support surrounding it. Ethics consultation, communication review, or morbidity-oriented reflection could ask whether disagreement was mistaken for incapacity, whether fear of paternalism produced premature withdrawal, or whether repeated professional pressure narrowed voluntariness. These are reflective questions, not performance standards.

Limitations

The framework is conceptual and cannot determine from labels alone whether a particular encounter preserves autonomy. A decision described as "shared" may refer to the process, the product, or both; conceptual analysis shows that these dimensions can diverge [27]. Observational, qualitative, and deliberative research would therefore be needed to determine whether the proposed categories can be identified reliably across actual clinical encounters.

Its scope is also decision-dependent. A systematic review found substantial variation in which clinical decisions are considered appropriate for shared decision-making [28]. The present account should therefore not be interpreted as requiring identical forms of support across routine, urgent, preference-sensitive, capacity-impaired, or severely constrained decisions.

The framework remains normatively contestable. It does not provide a validated threshold for "enough" support, settle disputes about paternalism, establish legal duties, or demonstrate improved clinical outcomes. Cultural, professional, and institutional differences may change what assistance is feasible and welcome. Future work should test the conceptual distinctions against difficult cases, patient and clinician perspectives, cross-cultural contexts, inter-rater classification, equity concerns, and competing normative theories. Vignette studies could examine whether independent observers distinguish abandonment from justified noninterference; qualitative research could test whether patients recognise the proposed support failures; and comparative normative analysis could challenge the framework from individualist, care-ethical, disability, and cultural perspectives. Consistent classification would establish usability rather than moral truth or clinical benefit.

Conclusion

Respect for autonomy can fail through excessive interference, but it can also become ethically thin when clinicians equate respect with withdrawal. This article has proposed relational abandonment to identify a restricted class of cases in which meaningful decisional need, feasible autonomy-compatible assistance, significant professional withdrawal, and preserved possibilities for choice converge.

The proposed Supported-Choice Framework treats professional support and patient decisional authority as distinct dimensions. Its central normative claim is not that clinicians should participate more in every decision, but that appropriate support and preserved authority can coexist. This makes room for recommendations, family participation, interpretive assistance, and patient-requested guidance while maintaining boundaries against manipulation, paternalistic substitution, and coercion.

The framework remains a conceptual synthesis rather than a validated instrument, legal standard, or universal clinical prescription. Its value depends on whether it can clarify cases without converting vulnerability into permission to override choice or converting relationality into compulsory involvement. The ethical objective is narrower: to respect the patient's decision without abandoning the person who must make it.

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